

COLONIAL HAUNTINGS: MIGRANT CARE IN A FRENCH HOSPITAL

Janina Kehr

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Abstract

In France, the treatment of migrant patients is haunted, but not overdetermined, by colonial practices of cultural essentialism and othering. Taking tuberculosis care in a public hospital as an example, I show how colonial hauntings surface in racialized patient-physician encounters and diagnostic practices. Colonial hauntings exist on two levels of awareness: on the level of the articulated, where physicians critique contemporary and historical politics towards immigrants, and on the level of the unarticulated, where, physicians – as they search to practice a caring medicine – unconsciously reproduce colonial forms of knowing and treating migrant patients as racialized others.

Keywords: France, colonial history, hospital ethnography, migrant care, othering, tuberculosis

Running Title: Colonial Hauntings

Media Teaser: In migrant hospital care, French physicians grapple with the unsettling specters of otherness in a country haunted by its colonial past.

Bionote

Janina Kehr is SNSF-Ambizione Research Fellow at the Institute of Social Anthropology at Bern University. She has published on tuberculosis, migrant care and global health. Her current research concerns austerity medicine in Spain, where she is investigating public health infrastructures at the intersection of history, debt economies, state bureaucracies and peoples' experiences. Address: University of Bern, Institute of Social Anthropology, Lerchenweg 36, 3012 Bern, Switzerland. Email: janina.kehr@anthro.unibe.ch

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The past ... becomes a ghostly presence, a palimpsest whose marks remain distinguishable beneath the surface of the present.

- Fiona Barclay, 2011:xx.

On November 23, 2005, Alain Lhostis – the president of the Board of Directors of the Public Assistance - Paris, France Hospitals (AP-HP) and a member of the French Communist Party – gave a long speech commemorating the 70th anniversary of Avicenne Hospital, a 500-bed university hospital situated in Bobigny, in the northern suburbs of Paris, France. “The history of Avicenne reveals a whole page of France’s history,” he stated. “The history of colonization and of immigration, the history of Seine-Saint-Denis, the history of social struggles and local ones.” He then proclaimed: “Ever since, Avicenne has been an activist hospital ... You pave the way towards what should and could be the hospital of tomorrow: a place where one practices a humane medicine.”¹

In his speech, Lhostis reflected on Avicenne’s past as a medical institution uniquely linked to colonial labor immigration at the height of the French empire. Inaugurated in 1935 as the so-called “Franco-Muslim Hospital,” the mission of the hospital was explicitly custodial: to treat and control “colonial subjects” from French North African² territories, who had been recruited to work in the metropole’s burgeoning factories (Rosenberg 2004:637). In its early days, colonial control at the “Franco-Muslim” hospital was enabled by close collaborations between the hospital administration and the police. Not only was the director of the hospital a former policeman, but the police quite literally “ran” the hospital in terms of its mission and everyday functioning (Rosenberg 2004:666). Information on patients’ employment histories, political activities, and medical information, all of which were gathered upon admission, were transmitted to the so-called “North African police,”³ in order to facilitate the intense and targeted surveillance of North African immigrants. Thus the hospital was set up to solve a medical, political and social problem all at once: to govern North African workers in mainland France and treat work-related diseases like tuberculosis

so that colonial subjects would not occupy space in other Paris, Franceian hospitals, in which beds were scarce (Rosenberg 2004). At the time, many French citizens believed North Africans carried infectious diseases like syphilis and tuberculosis in much greater numbers due to “congenital” (Rosenberg 2004:651) predispositions. The Franco-Muslim hospital was thus not only a space meant to govern colonial subjects, but also to protect French citizens from their “diseased” bodies. “By taking care of them, we are protecting ourselves and our fellow citizens” (Rosenberg 2004:651), Pierre Godin, the founder of the hospital, told the Municipal Council before construction had started. Since its founding, then, medical care at Avicenne hospital was entangled in colonial, racist, and national immigration politics, as well as responsible for perpetuating administrative violence, inequality, and medical racism. Some colonial-era predispositions endured across time, and push up into the present, albeit in diluted and transformed ways.

Avicenne was and remains “unlike the other” (Birsinger 2005:7) Parisian hospitals. As Lhostis’s speech made clear, even today its staff provides medical care to some of France’s most vulnerable and marginalized subjects in the region of Seine-Saint-Denis,⁴ which has a long history of immigration, economic deprivation, and social and racial tensions.⁵ Alongside the policing impulses, from its inception, the hospital also recruited doctors and nurses familiar with “Muslim customs and habits” to “treat Muslims in less deracinating manner than habitually” (Rosenberg 2005:18). The planners of Avicenne hospital promised “to treat North Africans in more familiar surroundings” by providing translators and care by “staff trained to understand North African languages and culture” (Rosenberg 2004:650). While colonial impulses to ensure control over North African patients were the primary institutional motives behind such humanistic and culturally sensitive approaches, this did not preclude the possibility of other forms of care. For example, “a handful of doctors ... looked out for their patients’ interest(s)” and challenged “common prejudice(s)” (666) by showing how social diseases like tuberculosis were a consequence of

poverty and “bad” living conditions, rather than any “biological abnormality or ethnic predisposition” (659).

COLONIAL HAUTINGS

In this article, I explore how the ambivalent colonial history of medical practice at Avicenne hospital lingers in the present, through the simultaneous presence of culturally essentialist and racializing forms of medical treatment of migrant patients, on the one hand, and socially and culturally conscious forms of migrant care, on the other. Colonial hauntings are “an animated state in which a repressed or unresolved social violence is making itself known, sometimes very directly, sometimes more obliquely” (Gordon 2011:xvi). Following Avery Gordon, I trace colonial hauntings in the clinic as a means to interrogate “their impact felt in everyday life, especially when they are supposedly over and done with” (2011:xvi). Though colonial hauntings involve and are produced by colonial experiences and colonial forms of knowing (xvi), they are not the same as colonial abuses of power. I speak of colonial hauntings in contemporary migrant care to distinguish medical practice at Avicenne today from the outright oppressive colonial violence at the hospital in the first decades of its existence (Rosenberg 2004) – like forced hospitalization and segregation - which has *de facto* ended, even if state violence towards some of its patients has not.

Avicenne is a particularly suitable place in which to trace colonial hauntings for a number of reasons. The hospital staff I had spoken with were very much aware of how traces of the hospital’s history as a colonial institution persisted in the hospital’s architecture, as well as in certain hospital policies, such as cultural competence. Further, as in the past, a large part of Avicenne’s patients today are immigrants without French nationality, racialized French nationals, or undocumented immigrants, many from former colonies. Many migrant patients at Avicenne are still subjected to the colonial epistemologies embedded in clinical practices and institutional routines, and they continue to live as “othered” subjects in contemporary France. Although colonialism in France has formally ended, I show how the

“specter of French colonial history” (Thomas 2013:13) continues to linger in cultural and racial forms of othering, both inside and outside the hospital.

In interrogating the ways colonial specters resurfaced in the treatment of migrant patients and physicians’ critiques of these processes, I contribute to anthropological studies of coloniality, medicine, and postcolonial (migrant) care (Belkacem 2015; Fassin 2001; Holmes 2013; Holmes and Castañeda 2016; Stevenson 2014). In France and elsewhere, migrant care has often been framed in terms of deservingness (Sargent and Larchanché 2011; Sargent 2012), structural violence (Farmer et al. 2006; Larchanché 2012) and humanitarian anti-politics (Fassin 2001, 2011; Ticktin 2011) to show the harmful consequences of social and legal exclusion, political marginalization, racialized treatments, and economic deprivation in the domain of health care. However, there is a relative absence in this literature of the critical reflections, desires, and affects of physicians, and their concerns and efforts in the care of migrant patients, with notable exceptions (Fadiman 2012; Giordano 2014, 2018). How can one analyze migrant care beyond a reading of professional failure, institutional and structural violence, or neglect, while not also dismissing them? How can we attend to professional desires for alternative forms of migrant care, while recognizing that they may not be fully realized? As recent anthropological work has shown, responding to these questions requires attending to the colonial hauntings and affective experiences that pervade contemporary medicine (Geissler and Lachenal 2016; Kilroy-Marac 2014; Stevenson 2012; Street 2012, 2014). In the second part of my argument, I highlight how physicians grappled with and tried to respond to colonial hauntings and their unresolved violence in France (Gordon 2011). Taking into account the political context, I attend to the ways that physicians reflected on state violence towards immigrants, exhibited “disturbed feelings” that could not be put away, and called for “something-to-be-done” (Gordon 2011:xvii). At certain moments, in some physicians’ engagements with patients, colonial hauntings coexisted with reflection and critique, as well as desires for more caring forms of attention to vulnerable migrant patients. This coexistence in the clinical everyday hints at how easily the colonial past slips into the

postcolonial present, reminding us of the impossibility of getting rid of the troubled history of French colonial medicine, of which medical professionals at Avicenne are at once “heirs and captives” (Purtschert 2010:1041). The co-presence also shows how medical professionals were affected by, and sometimes struggled with, the hospital’s and France’s colonial pasts, even if these feelings did not always rise to the level of explicit acknowledgement. This, in turn, illustrates the incomplete reckoning of colonial medicine’s traces, and shows how such traces continue to affect contemporary migrant care in diffuse ways.

METHODS AND CONTEXT

I conducted fieldwork in Avicenne’s Department of Infectious Disease and Tropical Medicine (IDTM) from October-December 2006 on practices specific to tuberculosis (TB) care. I visited the IDTM Department two to four times a week and participated in ward rounds, observed patient-physician encounters, shadowed resident physicians and interviewed TB patients at their bedside. As I was investigating the hospital’s response to TB, I focused on physicians’ tasks in TB care, their diagnostic discussions, their interactions with patients, and patients’ experience of disease and hospitalization. At the time, no formal ethics approval existed for qualitative research in medical institutions in France. However, I sought and obtained permission of the head of staff to do fieldwork in the IDTM department and presented regular oral reports about my research. I used oral informed consent during physician-patient encounters and to conduct interviews with patients, to whom I was introduced by the physicians as an anthropologist working on tuberculosis care. As the identity of the patients is subject to medical secrecy, all names are anonymized in this article. This fieldwork was part of a multi-sited ethnography on TB care in hospitals and TB prevention centres in France and Germany between 2006 and 2010. For this article, I analyzed my empirical material on TB care anew, by focusing on the ways colonial forms of othering haunted treatment encounters between physicians and TB patients at the Avicenne Hospital.

Tuberculosis is an old disease that haunts modern medicine and French society, primarily through the racialized bodies of ill immigrants. In France, TB is a doubly-othered disease, both geographically and temporally. While TB is racialized globally (McMillen 2015), in France, it is over-attributed to poor immigrants from the South, who are seen as bringing the disease with them to a country where it should no longer exist (Kehr 2016). Many people in France see TB as a disease from the past and the elsewhere: “present, again, while its time is not present anymore” (*là, à nouveau, quand son temps n’est plus là*) (Derrida 1993:87). TB is like “a ghost whose return repeats itself” (*un fantôme dont le retour ... se répète*) (32). Colonial legacies – in the form of the bodies of formerly colonized subjects who are sick, practices of othering and cultural essentialism – were very much present in the treatment of tuberculosis.

The majority of patients with TB I spoke to at Avicenne were migrants from former French colonies, including Mali, Senegal, Ivory Coast, Cameroon, and Morocco. Most immigrated with a work permit or tourist visa, but some were altogether without legal documents. Some lived in squats, others with family, while others were accommodated in public migrant housing facilities. All the TB patients I talked to at Avicenne hospital were non-French nationals, a fact that crystallizes the epidemiology of TB in France. Indeed, epidemiologically speaking, tuberculosis in France disproportionately affects people born in African countries, and, to a lesser degree, people born in non-EU European and Asian countries (Aït Belghiti and Antoine 2015). This is due not only to a heightened epidemiological risk in the home country, but also to the structural inequalities, administrative vulnerabilities, and precarities of living as migrants in France (Antoine 2006), which were oftentimes, but not always, visible to medical practitioners.

Outside the hospital, at the time of my fieldwork, the implementation of overtly racist policies towards minority French nationals, immigrants, refugees and asylum seekers (Fassin and Fassin 2006; Fassin 2015a) was also well underway. My 2006 fieldwork coincided with the highly publicized French presidential election campaign, which favored extreme right

wing and anti-immigration discourses. Public debates on immigration were dominated by the resurgence of colonial era imaginaries concerning what constituted cultural and political superiority (Purtschert 2010) and, more than this, “white normalcy”, which Dominic Thomas calls “the specter of French colonial history” (2013: 13; see also Stora 1999; Stora and Témime 2007). In February 2005, this specter had materialized in the highly controversial “law on colonialism,” as it was called in public debates, which obligated high school instructors to teach the “positive role”⁶ of French colonialism, as stated explicitly in the law. During public debates, African and/or Muslim immigrants—who comprise a significant part of Avicenne’s patients—were regularly presented as archetypal *Others* – be it in debates on the veil, banned in 2004 in public schools (Scott 2010), or discussions about naturalization procedures (Fassin and Mazouz 2007).⁷ Colonial forms of othering shaped discussions on immigration, and infused French political life more widely (Purtschert 2010). In the next section, I show how these forms of othering also structured encounters between physicians and migrant patient at Avicenne hospital.

BLACK SKIN, WHITE MASKS: HAUNTINGS OF RACISM IN TB DIAGNOSIS

I was sitting with a fourth year medical student, a junior and senior resident physician in the tiny residents’ room listening to their diagnostic discussions about newly admitted TB patients, when I glimpsed, through a small window in the door, a thin, black man wearing a white mask, lying on a hospital bed. He passed by, silently, like an apparition, pushed along the corridor by a white paramedic into an empty hospital room. I went back to listening to the case presentations of the ward round. Nathalie, one of the senior resident physicians, was asking the fourth year medical student about the anamnesis of a patient from Senegal: “What do you look for when a woman with African origin comes in with weight loss and cough?” The patient, a woman in her early thirties, was without a legal residence permit, and had been admitted to the department after having been referred by a practitioner. The answer was tuberculosis. There were many other instances during the ward rounds and diagnostic

discussions when tuberculosis was referred to as a “common disease” in Africa. “The Africans, they know tuberculosis,” Nathalie and her other colleagues regularly stated. When a new African immigrant patient’s anamnesis was discussed during ward rounds, phrases like “you have to think right away that this could be a TB” were very common.

Even though such diagnoses and efforts to make sense of particular symptoms may be legitimate in terms of global TB epidemiology (Antoine 2006), the diagnosis and treatment of TB was felt and weighed on migrant patients as embodied stigma. More than once, patients linked tuberculosis to their race or their country of origin. One young man from Haiti, James, who was without a residence permit, asked with anger, almost rage: “It is only black people, like me, who have TB here in France. Why do we have it?” I did not know how to respond. It became clear to me that he experienced TB as a racial injustice, even though he did not explicitly use the words “racist” or “racism.”

For other patients, the racial overtones of TB diagnosis and treatment at Avicenne overshadowed other aspects of their subjectivity that they considered important. Some migrant patients resented being lumped into reductive categories of otherness that seemed inevitable with a TB diagnosis. For example, Pascal, a retired man from Cameroon, had been working in France since the 1980s. We were chatting in his hospital room, while he was lying on the hospital bed with a slim, transparent oxygen tube resting across his cheekbones, which then fed into his nostrils. He told me in a slow, calm voice:

They told me that it’s TB, and I said: What? What’s this about? You can’t just get it in the metro or the taxi. I had the feeling that it was not me... Why did I get it? Why me? I am from a certain milieu, how to tell you, I was born in a hospital. In Africa, I come from a family that is rather well off. I don’t eat rubbish, I have good hygiene.

Having TB did not feel right to the elderly man. Pascal could not relate to the social milieus and conditions ordinarily associated with TB: poverty, bad hygiene, and bad food. For him,

Africa wasn't equivalent with these conditions, at least not the Africa he came from. Being diagnosed with TB left him with questions and feelings of shame and embarrassment. As a migrant patient, he felt that his class status did not count, only his identity as an immigrant mattered. Pascal explicitly distanced himself from such ascriptions through gesturing towards his upper-class status in his home country, but the epidemic holdovers from the country he had migrated from stuck to him. Though he had brought his country and its attendant disease risks with him, his class status had not migrated. He experienced TB diagnosis as a *declasserment* (demotion), which he felt more generally in his life in France.

At Avicenne, TB was explicitly taught and treated as an "immigrants' disease." In many of the clinical situations I witnessed, in the absence of bacterial proof of disease, an initial "suspicion of tuberculosis" was turned into diagnosis and treatment. This happened through what the head of staff called a "bundle of arguments." Besides clinical signs like cough and weight loss, or diagnostic technologies like radiography or TB skin testing, the most important arguments in situations where the TB bacteria could not be microscopically seen, were the "geographic origin of the patient" and their social situation in France, rather than their social status in their country of origin. In such situations, migrant patients from sub-Saharan and Maghreb countries were routinely put on a so-called *traitement d'épreuve* (TB trial treatment), as if the patients brought with them a diseased environment to be treated, despite clinicians remaining uncertain about the existence of tuberculosis in their bodies.

These overdeterminations of racialized origins accompanying TB diagnoses did not always go unnoticed. At the beginning of my fieldwork, the department's psychologist explicitly told me that she saw TB as a "racist diagnosis." I was complaining to her about the protective masks that doctors, nurses, and I had to wear when going into a TB patient's room. I had been coming to the hospital for a few days and had talked to a handful of TB patients, some of whom were in *isolement* (isolation care) due to a risk of contagion. As indicated by a highly visible sign at the door of the hospital room, everyone entering the room had to wear a mask. I told the psychologist that I did not feel comfortable wearing the mask during my

interviews, but that I couldn't really say why. She responded:

It's difficult to recognize the people, you don't know who is behind the mask. You know, this idea of the pestilent, the rejection of normal social codes. The mask is an exterior sign of the disease. The mask, the Star of David, it all gets mixed up. Even if it is us and not the patient who actually wears the mask, the mask is a mirror. Even if it's not they who wear the mask, it's they who wear the mask, you see? The one who has to wear the mask must protect himself from them. Imagine an African patient. The white coat, the white mask, everyone protects himself or herself from him. What do you think this provokes? It's neocolonial. This is what's in the air when one wears a mask. There is a whole history behind [it]. The disease is not visible, but the mask is. The mask covers and uncovers... Sometimes patients say about the physicians, 'They look for TB because I am black. They don't even look for something else. They suspect me to have TB because I am black'. A TB diagnosis is racist.

The psychologist, herself white, like me, reflected on racism, poverty, and what she termed "the neocolonial" in the clinic. By referring to the Star of David, which Jews were forced to wear publicly in Nazi Germany, she alluded to the destructive power of symbols when they are used as racist branding devices. The psychologist used the metaphor of the mask to explain how TB diagnoses are haunted by racism, even if they were not felt as outrightly racist by some patients and doctors. Through a psychoanalytical reflection on the white mask, the psychologist linked everyday medical practices such as hygiene and diagnosis to colonial politics of racial differentiation, stigmatization, and fear that were re-actualized in the present. Through the phrase, "there is a whole history behind" the mask, the psychologist acknowledged the diffuse presence of colonial history and the practices of colonial medicine that continue to shape the care of TB patients.

At the same time, the specter of racism haunting TB diagnoses is different from overtly racist medical etiologies of the past, in which diseases such as tuberculosis were seen as being due to the "biological abnormality or ethnic predisposition" (Rosenberg 2004:659)

of North African patients. While epidemiological risk factors of a disease are important to take into account in a low-burden country like France, diagnostic practices cannot be neatly disentangled from the long history of TB as an immigrants' disease. In medical trainings at the IDTM department, patients' origin is taught to matter – and sometimes gains priority over other aspects of their lived experiences.

In the next section, I look at the ways in which another aspect of patients' supposed origin – namely culture and religion – came to matter in the clinical everyday. I reveal how the “cultural competence” (Heidenreich and Bouchaud 2004:3) approach practiced in the IDTM department unconsciously speaks to Avicenne's past as a Franco-Muslim hospital, set up to treat “natives ... in a milieu corresponding to their habits and customs” (Sellier, cited in Rosenberg 2004:650).

THE COLONIAL RESONANCES OF CULTURAL COMPETENCE

During a session of outpatient care for TB patients, I was sitting with Nathalie behind her wooden desk in a starkly lit, greenish hospital room on the ground floor of the outpatient clinic, waiting for the next patient to arrive. Nathalie had been working in the IDTM department for a few weeks, having returned to France from a six-month humanitarian mission with Doctors for the World in “Africa.” While waiting for the next patient, Nathalie said:

What irritates me most is when people don't come to the consultation. It means that they don't take their treatment. This means, in turn, that I can't do my job as I should be doing it. Many patients here don't speak French, they have a different culture; they just don't worry about TB. This being said, Africans aren't the least compliant, they are afraid of TB, as they are afraid of AIDS. TB, for them, is a shameful disease. But, actually, I don't know anything about all this.

Nathalie's words were filled with both anger and doubt. On the one hand, she saw her "African" patients as highly determined by their own, emic cultural representations of disease, which exasperated her. Her attitude reflects what scholars in France have described as the cultural essentialism present in medical institutions, that is, when physicians and nurses attribute the difficulties of treating and caring for migrant patients to their patients' cultural or religious alterity (Fassin 2004; Kotobi 2000; Nacu 2011). Colonial processes of othering explain and reify migrant patients' subjectivities as incommensurably different from French born patients.

Uncanny colonial hauntings made themselves present in the clinic in embodied form, here in Nathalie's anger and feelings of blame towards her migrant patients. She was not conscious that she was channeling longer histories of French colonial medicine, when patients were read as determined by traditional medical and cultural practices and beliefs (Fanon 1965). Her affects were the effect of Nathalie's grappling with her patients' "difference," a difference that she disdained. But, at the same time, Nathalie also voiced insecurities about her capacity to know the feelings, perspectives and experiences of her migrant patients, stating that, "actually I don't know anything about all this." She thereby suggested that her own lack of knowledge might be contributing to treatment interruption or noncompliance. She expressed an ambivalence towards the use of cultural competence approaches in the clinic, which were highly valued by the IDTM head of staff, yet only incompletely followed through. Couched in frustrated words and tinged with racist tendencies, Nathalie nonetheless spoke to the inadequacy, ineffectiveness and uneasiness that came with attempts to use cultural knowledge in the clinical encounter.

For the IDTM head of staff, the recognition and knowledge of patients' cultural particularities was an essential precondition for treating migrant patients. Under his guidance, Avicenne hospital became one of 12 "migrant friendly hospitals" in Europe, through an initiative sponsored by the European Commission in the early 2000s.⁸ At Avicenne, a particular focus was laid on "cultural competence." According to this approach, cultural

particularities were present in migrant patients' approaches to disease, death, religion, food habits, gender relations and language, and needed to be recognized and attended to by trained medical staff. "For the treatment encounter to function," he told me, "these must be taken into account." And yet, attempts to be sensitive to cultural difference or to put "cultural competence" to work were ambivalent affairs. Oftentimes, cultural competence unintentionally slid into cultural essentialism. The insistence on cultural competence, to me, also uncannily resonated with the colonial humanism of the Franco-Muslim hospital, which strongly depended "on a positive recognition of religious difference" (Rosenberg 2004:651).

Such resonances became most clear during physician-patient interactions in the weekly ward rounds. Weekly rounds at the IDTM department were highly structured rituals and educative performances, in which all physicians and third and fourth year medical students of the department discussed clinical "cases," wrote and re-wrote patient files, and debated anamnesis, diagnoses, exams, and interventions, often for two or more hours. Only after the revision of patient files was completed in the department's library did the medical staff actually go and see patients in their rooms. One of the patients was Mamadou.

Mamadou had been hospitalized for over a week due to a relapse of tuberculosis. The chief physician was the first to enter his room, which was shared with another patient. The winter light was already low. "Good afternoon," we collectively uttered. The chief physician took a chair and moved it close to the patient's bed. He sat down next to Mamadou, looked at him and asked in a calm voice how he was feeling today. Mamadou said he was doing ok and the chief physician continued:

Chief Physician: Where does your name come from?

Mamadou: Mali.

CP: You have tuberculosis, but we believe it was not well treated. In the patient file I read that you forgot to take your medicine from time to time, is that right? You are a Muslim? The disease comes from God then, doesn't it?

M. No.

CP: The disease does not come from God, is it not God that decides?

M: Ah I see, well, yes.

CP: And drugs, they come from doctors. And doctors, they take their power from God. We do not know for sure if you have a pulmonary infection or a relapse of tuberculosis. So we will have to prescribe the TB treatment again.

M: If you want to.

CP: Do you have any more questions?

M: When will I be released from hospital? I want to go back to my country, I have a house to build there.

CP: Do you want to go to Mecca?

M: Mali is Mecca for me.

CP: And to be able to go back to your country, you have to be in good health and take your drugs.

This short dialogue, which took place in French and which I scribbled down in fragments in my notebook in the hospital room, exemplifies encounters with migrant patients in a mode of cultural *othering*. As Mamadou's short, oftentimes monosyllabic answers show, this mode is characterized by the relative muteness of racialized patients concerning their supposed cultural or religious identity, as well as the white chief physician's leading and essentializing questions, which echo those Nathalie had earlier expressed. The chief physician was concerned that Mamadou might not take his medication as prescribed, and worked to ensure his compliance and adherence by appealing to God from what he assumed was the patient's perspective. In so doing, he forwarded a very simplistic view of Islam, which served to reify Mamadou as a traditionalist *other*. Meanwhile, Mamadou had rather different concerns. Having lived and worked for over 20 years in France, he wanted to move back to Mali to finish his house. It was not Mecca, or religion, which mattered most to him, but his ability to return home.

During this ward round, the patient's otherness was explored as a closed category based on "cultural assumptions" (Kleinman and Benson 2006:1673), typical of a cultural competence approach. The head physician saw Mamadou was a Muslim, and therefore addressed him primarily in religious terms, while neglecting other aspects of his identity. Despite attempts by the head physician to foster an empathetic form of relating, which manifested in his gestures – sitting beside the patient, talking caringly, and thus performing proximity rather than knowing distance – he over-attended to Mamadou's religious identity, and unconsciously imposed on him his own knowledge and reasoning about Islam. Colonial ways of knowing and addressing the Other lingered in the encounter, in which "the Other does not need to be studied, as all is already known about him" (Fassin 2000:241). Such forms of othering are rooted in a colonial epistemology which "tells the truth about the Other in his irreducible difference" (238), while foreclosing true understanding. Such colonial modes of knowing enculturate migrant patients into behaviors and power relations that are not only expected but demanded of them. During the ward round encounter, Mamadou tried to resist the othering gently but firmly, and his timid and yet insistent questions exposed a much more complex identity than those accorded to him by the white physician.

Colonial resonances of cultural competence, which reproduced colonial power relations and epistemologies, coexisted with physicians' sincere efforts to attend to their patients' linguistic, social, and political economic needs. The use of independent language translation services during medical encounters, the provision of food prepared by a local women's association, the holding of Muslim religious services in the hospital, and taking time to listen to patients' migration trajectories, were all examples of the kinds of caring attention that many patients valued. Also, undocumented patients were accompanied to the offices of the "health rights space" of the French Committee for the health of exiles (COMEDE) of which the head physician was part, located within Avicenne hospital, so they would receive juridical support concerning residency permit and insurance rights. In France, such attention to cultural, religious or legal needs within public institutions cannot be taken

for granted, as a strong ideology of assimilation and *laïcité* (secularity) pervades the governance of otherness (Fassin 2015b). In a political context of “abstract universalism according to which egalitarianism must be premised on forgetting one’s own origins and affiliations” (Boubeker 2013:193), attention to migrant patients’ religious affiliations as well as their political and economic living realities was a form of resistance to homogenizing state politics that actively disavowed difference.

At the IDTM department, many doctors felt something needed to be done to acknowledge migrant patients’ existences outside of the clinic, and to address them as vulnerable human beings in need of specific social and juridical attention in a country haunted by the after-effects of colonial history. These doctors offered a contrasting etiology for TB other than race or national origin, instead emphasizing the forms of institutional racism and unsanitary living conditions that migrants faced once they were already in France. As the head of staff wrote in the final report for the migrant friendly hospital initiative, the majority of patients were “immigrants from the former French colonies as well as from countries where civil war and difficult economic situations create pressure to emigrate” (Heidenreich and Bouchaud 2004:2). Difference and inequality simply could not be disavowed, but neither could patients be reduced to their cultural, religious, or ethnic otherness.

SOMETHING TO BE DONE

During the weekly ward round, the head of staff rigorously taught his students and resident physicians that patients’ social, juridical and political economic lives outside of the hospital needed to be known in order to adapt care to those conditions. He regularly repeated during staff meetings that, it is “really important to always exactly specify patients’ socioeconomic situation by asking: Where does a patient live? In a migrant shelter? Does he or she work? Does he or she have an income? Does he or she have documents? Is he or she in a catastrophic situation?” Once, during case discussions in the library, the head physician got

very angry with a fourth year student, who had difficulties presenting his patient's history. Almost shouting, he said: "You are kidding me. Your patient has been in the hospital since yesterday and you don't even know how he lives. If you don't ask this of your patient, this means to me that you are not interested in him, that you don't care."

Questions of material existence were part of the catalogue of questions asked to all patients admitted to the IDTM department, because many patients suffered not only from multiple diseases, but also from high levels of poverty and overlapping juridical, economic, and political violence, all of which carried the potential to aggravate disease. The aggregate effects of poverty and marginalization were especially striking for those TB patients who lacked legal residence permits and depended on a special regime of medical insurance, named *Aide Medical d'Etat* (AME), which enabled limited access to care (Izambert 2010). During my fieldwork, many of the discussions I heard among physicians circled around their concerns for the medical consequences and health effects of the upcoming presidential elections, during which conservatives declared wanting to restrict the AME regime if put into power. During lunch meetings and corridor conversations in the autumn and winter of 2006, the health professionals I talked to spoke vehemently against what they described as nationalist and xenophobic political discourses, and worried about their future impacts on migrant care. Constant precarity, the fear of expulsion, and the institutional mistreatment of migrant patients outside Avicenne were topics that physicians not only explicitly discussed with me, but about which they also wrote (Bouchaud 2009).

Anne, a pulmonologist at Avicenne Hospital and the head of the regional centre for TB control, was especially outspoken on the subject of migrants' living conditions in France and associated medical dangers. In our many conversations, she regularly accused France's immigration politics of causing high levels of disease among her migrant patients, thereby pushing back against easy otherings of patients and their diseases. During one of our amicable meetings in her living room, in which an entire book shelf was dedicated to anti-colonial thinkers, from Frantz Fanon to Abdelmalek Sayad, she said:

You know how persons from Africa are taken into Paris, France shelters? It's pure horror. Of course, it's "nice" in a way, there is grilled corn, you eat your *poulet yassa* (Senegalese style chicken) for a euro and so on. But four or five people share a small room. It should simply be illegal that people have to live in these conditions. It's shameful, it's really shameful.

Anne was upset about the poor conditions in migrant shelters and condemned the politics that allowed them to persist. She felt ashamed of her country and the harmful consequences arising from what she identified as the state's illegitimate treatment of immigrants. Her feelings of shame were an artifact of French colonial history that in her spare time, she struggled to understand through reading anti-colonial and post-colonial thinkers. In her eyes, high levels of tuberculosis and delayed access to care were consequences of France's immigration politics, which showed that the state did not care about migrants, many of whom who were being housed in unacceptable living conditions.⁹

Immigration politics were, to her, the real underlying causes of tuberculosis, not a patient's country of origin or race. The "political etiology" of TB, to use Sherine Hamdy's expression, was the "outcome of social and political failures" (2008:554). When I asked Anne whether a specific form of migrant care should exist in this situation, she said: "No. We should just listen to them and consider them as normal persons, not as a charge. Just sit down, talk to them: How are you, how is your wife, where do you live etcetera." In Anne's reflections on migrants' existences outside of the clinic, "disturbed feelings" of shame and guilt appeared, about which something needed to be done, "something different from before" (Gordon 2011:xvi). What should be different, in Anne's eyes, was to recognize migrants not primarily as migrants, but as persons with histories, lives, and feelings who must be heard.

Like Anne, other health professionals at Avicenne were well versed in colonial literature and reflected on the hospital as a space entangled with French colonial history and contemporary xenophobic politics. They worried about a nationalist, xenophobic future and an ever more restrictive political context as a potential danger to their migrant patients

(Fassin 2007; Izambert 2010). Some tried translating this worldview into actual clinical practices, such as teaching young resident physicians and medical students that it was crucially important to know patients' living conditions outside of the hospital, to listen to patients as persons, and to show interest in their lives, which were oftentimes full of legal and economic uncertainty and hardship.

In these instances, physicians recognized the hospital as an institutionalized space entangled in larger injustices and colonial hauntings. But the hospital was also a space where something different needed to be done, where assistance and protection needed to be offered. While being entangled in colonial biopolitics, the hospital also potentially existed as a space separate from the state, in which some patients found intermittent peace and rest from the consequences of restrictive immigration policies. For instance, Amy, a young woman from the Ivory Coast with a temporary residence permit, had migrated to France a few months earlier, after having worked in Mali, then Belgium, where she had lived a whole winter in unheated housing. In France, she had no work permit and was housed with her extended family, with no privacy whatsoever. During one of our multiple conversations during her hospital stay, she told me: "I need peace. All these pharmaceuticals, the disease. I need a calm setting, where I can be with myself, where I can be alone. If the setting is overburdened, I fall ill. The disease, the exhaustion, the environment, all these act on my organism and on my mood. In the hospital, I am in peace. I feel liberated, nobody touches my stuff" (20 November 2006). At Avicenne hospital, Amy felt at peace.

CONCLUSION

Avicenne hospital is a place thick with history, "haunted by past structures of meaning and material presences from other times and lives" (Till 2005:9). The hospital was built as a colonial institution to protect French citizens from the supposedly diseased and dangerous bodies of colonial subjects, and to keep them alive through culturally-sensitive medical care. While the overt colonial politics of healthcare provision and their attendant biopolitics of

survival and control had disappeared, traces of colonial knowledge and forms of care, such as patient othering and racializing in the clinic, persisted. These intermingled with political critique and attempts for attentive and individualizing forms of migrant care. In some instances, physicians' and patients' grappling with colonial history was explicitly, as in physicians' critique of France's immigration policies and their more expansive understandings of TB etiologies beyond national origin or race. In other instances, as in ward rounds or diagnostic discussions, colonial hauntings remained unreflected and unnoticed. Colonial hauntings thus existed on two levels: as articulated, when contemporary immigration politics were critiqued or felt as the unresolved social violence of French colonial power, and as unarticulated, when colonial forms of othering migrant patients occurred as embodied medical practice and institutional routine. I suggest that colonial othering and political critiques were co-present at Avicenne hospital, albeit at different levels of awareness.

In both instances, though, feelings that something needed to be done emerged, in which physicians attempted to recognize their own limitations, voiced disturbed feelings or tried to make space for their migrant patients' particular cultural and sociological existences inside and beyond the clinic. Such desires for alternative forms of migrant care occasionally materialized in the provision of customary food, religious services or juridical aid, as well as when physicians took time to sit down at the patients' bedside, sometimes holding their hands, and talking with them about their trajectories and histories. Anne, the pneumologist, described that recognizing and attending to her patients meant relating to them beyond the hospital, beyond disease.

Even if such efforts were haunted by colonial epistemologies, they were not determined by them. Rather, they illustrate what Lisa Stevenson (2015) has called the ambivalence of desire that traverses any form of care, an ambivalence in which caring for the other takes place within colonial imagination and hauntings. Physicians' desires for different or alternative forms of migrant care were thus never entirely removed from, or outside of, the

power structures of longstanding violence towards immigrants, racializations within and beyond the hospital, or actualizations of cultural essentialism with all their colonial resonances. Yet some physicians attended to, critically reflected on, and tried to distance themselves from these colonial hauntings and traces of the past, and thus suggested possibilities for change.

If anthropology's aim is to "create the conditions for new thoughts" (Strathern 1988:20), then, I argue, our investigations of hospital medicine might be a good place to start imagining alternative forms of migrant care in the clinic through a reflection on its colonial hauntings and physicians' grapplings with them. Hospital ethnography has recently started to explore the affective terrains that haunt the exercise of medical practice in the hospital (Kilroy-Marac 2014; Livingston 2012; Street 2014, 2012). Ethnography that ventures into terrains of haunting and desire, especially in the domain of migrant care, can help show how contemporary medicine is an authoritarian practice haunted by colonial pasts, and how it consists of desires for alternative forms of care, with all its attendant ambivalences. Exploring the multiple shades of the ambivalence of care, in the clinical everyday, but also outside of it – be it in physicians' publications, intellectual strivings, or activism – allows us to see how larger visions of medicine's politics are being channeled, even if they do not translate into clinical practice - yet.

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NOTES

¹ Lhostis, Alain. “70 Ans de l’hôpital Avicenne.” Bobigny, November 23, 2005.

http://archives.alainlhostis.net/article.php3?id_article=83, website last accessed on October, 18, 2016. For an overview of historical sources on Avicenne hospital, see <http://odysseo.generiques.org/ark:/naan/a011442407908mJL9Cw>.

² “French North Africa” was an ensemble of colonized territories (now Morocco, Tunisia and Algeria) ruled by France. Algeria particularly was governed as an integral part of metropolitan France, as one of its départements.

³ This police division, called *Brigade nord-africaine*, was a special police department set up in 1925, to control North Africans in the metropole. It operated until 1945. Avicenne hospital was under its command. For a critical history of the Brigade, see Blanchard (2011).

⁴ Seine-Saint Denis is a French department bordering Paris at the North-East. It is one of the economically most disadvantaged departments in France, with levels of poverty approaching 28 percent and unemployment rates reaching up to 18 percent (2013 data). Seine-Saint-Denis is a highly diverse department: 27 percent of the population are immigrants, from which 23 percent come from non European-Union countries (2008 data). All data from the National Institute of Statistics and Economic Studies (INSEE), accessible online www.insee.fr.

⁵ For a history of social struggles, especially communism, in Bobigny, where the hospital is located, see Stovall (1990). See also Giblin (2016) and Le Moigne, Smithsimon and Schafran (2016) for the entanglements of immigration, deprivation and their related social and racial politics in Seine-Saint-Denis.

⁶ Article 4 of the law specifies that school manuals should insist on the “positive role of the French presence overseas, specifically in North Africa” (Loi N° 2005-158 Du 23 Février 2005 Portant Reconnaissance de La Nation et Contribution Nationale En Faveur Des Français Rapatriés).

<https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000444898&dateTexte=&categorieLien=id>.

⁷ Historians of colonial France (Fanon 1965; Scott 2010; Stora 1999) have shown that Muslim religion, customs and clothing have served since colonial times as archetypal blueprints to construct a republican *Other* in a context where “cultural assimilation” has long been a “defining characteristic of Frenchness“, and where the representation of France as “homogeneous nation” based on common language, culture and adherence to republican values of universalism is an old one (<https://www.ias.edu/ideas/2016/scott-veil-in-france>). Today, Muslims are still (or again) France’s archetypal *Others* in a racialized and increasingly racist public debate, where ethnicity and religion are often conflated (Billaud and Castro 2013; Mazouz 2017; Scott 2010).

⁸ For more information on this initiative, see <http://www.mfh-eu.net/public/home.htm>.

⁹ For the colonial hauntings of migrant housing in Paris in specific shelters, the so-called *foyers de travailleurs migrants*, see Bernardot (2008).

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